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MDS Alert

SPECIAL NEW YEAR SUPPLEMENT - Find Out What The New Quality Measures Have In Store

The risk adjustment is a whole new ballgame.

Ready or not: The new **Nursing Home Quality Initiative** publicly reported quality measures soon will make their debut. And if you thought the first round of QMs posed a learning curve, prepare for another steep climb, especially in figuring out the new risk adjustments.

The **Centers for Medicare & Medicaid Services** plans to implement the new QMs in January, an agency official confirmed for **Eli**. While CMS had not, at press time, posted the list of new quality measures the agency will be using, the new measures will be essentially the same as the ones endorsed by the **National Quality Forum**, according to the CMS official.

The QMs may be the same, "yet some of the exact specifications need to be completed and revised," adds **Brown University** geriatrician **David Gifford, MD, MPH**, chief medical officer at **Quality Partners of Rhode Island**, one of the quality improvement organizations (QIOs) involved in the NHQI.

"For example, the NQF-endorsed measure may not specify the exact MDS coding," Gifford says. "Or the coding may be specified, but the QM doesn't address exceptions such as how to deal with missing data in calculating the covariates or exclusions."

Look for These Changes

Changes to the existing QMs as endorsed by the NQF include:

1. Elimination of the chronic care infection measure. Instead, a QM will report the percentage of residents with a urinary tract infection (UTI). "While the infection measure was a composite of several infections and symptoms, UTIs and pneumonia were the major drivers of the measure," Gifford explains. "And not all states captured the other information (infections, fever, pneumonia) on the quarterly MDS assessments for the infection measure. Thus, UTI was primarily driving the measure in those states."

2. Elimination of the post-acute "improvement in walking" from the 5-day to the 14-day MDS.

3. Addition of a post-acute pressure ulcer measure that reports the percentage of residents whose pressure ulcers have not gotten better from the 5-day to the 14-day assessment. Providers are concerned about this one, "since the assessment reference date for these two assessments can be as little as three days apart," notes **Rena Shephard, MHA, RN, FACDONA**, president, **RRS Healthcare Consulting Services** in San Diego, and chair of the **American Association of Nurse Assessment Coordinators** in Denver. "For example, the ARD for the 5-day assessment can be as late as day 8 of the resident's post-acute stay - and the ARD for the 14-day MDS [can be] as early as day 11."

   Gifford believes, however, that nursing homes may be surprised at how good they look on this postacute measure. "Providers tend to forget that many stage 1 and 2 ulcers heal in a few days," he notes. And while providers tend to remember the stage 4 ulcers, he adds, the reality is that most residents actually are admitted with the earlier stage ulcers.

   New chronic care measures include:

4. Percentage of residents who are bedfast all or most of the time.

5. Percentage of residents with a decline in locomotion.

6. Percentage of residents who have become more depressed or anxious.

7. Percentage of residents with bowel or bladder incontinence.

8. Percentage of residents with indwelling catheters. This measure will show if facilities are using more Foleys to manage urinary incontinence.

Flap Over FAP

The new QMs eliminate the facility-adjusted profile, which means the chronic care pressure ulcer and short-stay delirium measures won't be adjusted at the facility level, as they are currently.

Providers that admit a lot of wound-care patients have expressed concern about the elimination of the FAP because it provided some level of risk adjustment for their pressure ulcer scores.

"The new chronic care pressure ulcer measure is risk-stratified and the exclusions are still there, such as residents with end-stage disease," Shephard notes. "Yet it's going to be difficult to know - especially until the industry gets a handle on the covariates - whether the adjustments level the playing field enough for providers who admit high numbers of residents with pressure ulcers or other chronic problems," she adds.

Yet the lack of a FAP might not be that big of big problem, say some experts. "If a facility admits a large number of wound-care patients, most of the patients will be defined as high risk and be reported in that category if they are still in the facility for the quarterly MDS," Gifford offers. "And many of the wounds won't be captured on the quarterly assessment MDS, since a large number of them will be healed by then," he says. Gifford also points to data compiled in the late 1980s showing that the natural healing time for pressure ulcers in the nursing home setting is three to six months. "Today wound care specialists use aggressive treatments and can heal ulcers much more quickly," Gifford notes.

Tip: "Facilities that specialize in wound care should be able to present data to show surveyors and families that they do admit a lot of residents with pressure ulcers, and the actual healing rates for those wounds," Gifford suggests.

Win Some, Lose Fewer

In lieu of FAPs, the new quality measures rely on a large number of resident-level risk adjustors, which gets very complicated. For example, the current pain QM uses Section B4 (moderate or severe impairment in skills for daily decision making) as a covariate. By contrast, the new QMs rely on a more complex cognitive performance scale with additional MDS items to risk adjust residents for pain. And while some covariates bump down a score to avoid penalizing the facility for admitting high-risk residents, the cognitive items will increase a facility's pain measure. The risk adjustment in the latter case accounts for the fact that residents with cognitive impairment can't communicate pain verbally as well as someone who is cognitively intact, Shephard says.

Tip: Your facility can mitigate the cognitive risk adjustment for the pain quality measure by care planning to prevent avoidable factors (clinical, interpersonal and environmental) that increase residents' confusion and delirium. That strategy will improve residents' cognitive performance scores on the MDS, Shephard says.